

Facility Name & ID Number Provena McAuley Manor

0042879 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,755	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	87	TOTALS	87	31,755	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,312	10,265	11,286	22,863	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,312	10,265	11,286	22,863	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.00%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 12/1/1997

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 87 and days of care provided 10,591

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/09 Ending: 12/31/09

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	196,529	38,490	8,508	243,527		243,527		243,527		1
2	Food Purchase		131,175		131,175		131,175	(6,841)	124,334		2
3	Housekeeping	149,117	29,472		178,589		178,589		178,589		3
4	Laundry	30,842	2,084	64,057	96,983		96,983		96,983		4
5	Heat and Other Utilities			131,956	131,956		131,956	2,720	134,676		5
6	Maintenance	87,853	34,364	76,485	198,702		198,702	43,555	242,257		6
7	Other (specify):* Pastoral Care	36,837	3,082	42,638	82,557		82,557	(26,069)	56,488		7
8	TOTAL General Services	501,178	238,667	323,644	1,063,489		1,063,489	13,365	1,076,854		8
	B. Health Care and Programs										
9	Medical Director			3,454	3,454		3,454		3,454		9
10	Nursing and Medical Records	2,303,012	238,831	70,417	2,612,260		2,612,260		2,612,260		10
10a	Therapy			839,726	839,726		839,726		839,726		10a
11	Activities	67,687	2,835	17,303	87,825		87,825	219	88,044		11
12	Social Services	45,999	7	2,464	48,470		48,470		48,470		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,416,698	241,673	933,364	3,591,735		3,591,735	219	3,591,954		16
	C. General Administration										
17	Administrative	360,043	17,337	734,308	1,111,688		1,111,688	(307,131)	804,557		17
18	Directors Fees										18
19	Professional Services			8,507	8,507		8,507	49,233	57,740		19
20	Dues, Fees, Subscriptions & Promotions			46,494	46,494		46,494	(25,049)	21,445		20
21	Clerical & General Office Expenses			41,904	41,904		41,904	(3,956)	37,948		21
22	Employee Benefits & Payroll Taxes			788,373	788,373		788,373	236,965	1,025,338		22
23	Inservice Training & Education			6,229	6,229		6,229	2,381	8,610		23
24	Travel and Seminar			3,185	3,185		3,185	4,195	7,380		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			91,228	91,228		91,228	(59)	91,169		26
27	Other (specify):* Bad Debt			28,664	28,664		28,664	(28,664)			27
28	TOTAL General Administration	360,043	17,337	1,748,892	2,126,272		2,126,272	(72,085)	2,054,187		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,277,919	497,677	3,005,900	6,781,496		6,781,496	(58,501)	6,722,995		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Provena McAuley Manor

#0042879

Report Period Beginning:

01/01/09

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			321,112	321,112		321,112	72,835	393,947			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							332,805	332,805			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							21,224	21,224			34
35	Rent-Equipment & Vehicles			6,977	6,977		6,977	2,645	9,622			35
36	Other (specify):*											36
37	TOTAL Ownership			328,089	328,089		328,089	429,509	757,598			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			727,902	727,902		727,902	(288,358)	439,544			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,633	47,633		47,633		47,633			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			775,535	775,535		775,535	(288,358)	487,177			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,277,919	497,677	4,109,524	7,885,120		7,885,120	82,650	7,967,770			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Provena McAuley Manor

ID# 0042879

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Development Office Supplies	\$ (36)	7	1
2	Development Other Supplies	(76)	7	2
3	Development Food	(308)	7	3
4	Development Postage/ Mail/ Courier	(15)	7	4
5	Development Education/ Conference	(40)	7	5
6	Development Misc	(25,594)	7	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(26,069)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena McAuley Manor# 0042879

Report Period Beginning:

01/01/09

Ending:

12/31/09

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,893)	2,052	0	0	0	0	0	0	0	0	0	(6,841)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,720	0	0	0	0	0	0	0	0	0	2,720	5
6	Maintenance	0	733	42,822	0	0	0	0	0	0	0	0	43,555	6
7	Other (specify):*	(26,069)	0	0	0	0	0	0	0	0	0	0	(26,069)	7
8	TOTAL General Services	(34,962)	5,505	42,822	0	13,365	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	219	0	0	0	0	0	0	0	0	0	219	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	219	0	0	0	0	0	0	0	0	0	219	16
	C. General Administration													
17	Administrative	0	(291,056)	(16,075)	0	0	0	0	0	0	0	0	(307,131)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,964	18,269	0	0	0	0	0	0	0	0	49,233	19
20	Fees, Subscriptions & Promotions	(30,518)	5,469	0	0	0	0	0	0	0	0	0	(25,049)	20
21	Clerical & General Office Expenses	(10,335)	6,379	0	0	0	0	0	0	0	0	0	(3,956)	21
22	Employee Benefits & Payroll Taxes	0	84,848	152,117	0	0	0	0	0	0	0	0	236,965	22
23	Inservice Training & Education	0	2,381	0	0	0	0	0	0	0	0	0	2,381	23
24	Travel and Seminar	0	4,195	0	0	0	0	0	0	0	0	0	4,195	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(59)	0	0	0	0	0	0	0	0	0	(59)	26
27	Other (specify):*	(28,664)	0	0	0	0	0	0	0	0	0	0	(28,664)	27
28	TOTAL General Administration	(69,517)	(156,879)	154,311	0	(72,085)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(104,479)	(151,155)	197,133	0	(58,501)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena McAuley Manor# 0042879

Report Period Beginning:

01/01/09

Ending:

12/31/09

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	8,722	0	64,113	0	0	0	0	0	0	0	0	72,835	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,850)	0	339,655	0	0	0	0	0	0	0	0	332,805	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	21,224	0	0	0	0	0	0	0	0	21,224	34
35	Rent-Equipment & Vehicles	0	0	2,645	0	0	0	0	0	0	0	0	2,645	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,872	0	427,637	0	429,509	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(288,358)	0	0	0	0	0	0	0	0	0	0	(288,358)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(288,358)	0	0	0	0	0	0	0	0	0	0	(288,358)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(390,965)	(151,155)	624,770	0	0	0	0	0	0	0	0	82,650	45

Facility Name & ID Number

Provena McAuley Manor

0042879

Report Period Beginning:

01/01/09

Ending:

12/31/09

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 2,052	\$ 2,052	1
2	V	5 Utilities		Provena Senior Services	100.00%	2,720	2,720	2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	733	733	3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	219	219	4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	5,621	5,621	5
6	V	17 Administrative Salaries	491,820	Provena Senior Services	100.00%	195,143	(296,677)	6
7	V	19 Professional Services		Provena Senior Services	100.00%	30,964	30,964	7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	5,469	5,469	8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	6,379	6,379	9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	84,848	84,848	10
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,381	2,381	11
12	V	24 Travel		Provena Senior Services	100.00%	4,195	4,195	12
13	V	26 Insurance		Provena Senior Services	100.00%	(59)	(59)	13
14	Total		\$ 491,820			\$ 340,665	\$ * (151,155)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 2,735	\$	2,735	15
16	V	32 Interest		Provena Senior Services	100.00%	166,061		166,061	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	21,224		21,224	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,645		2,645	18
19	V	17 Admin Salaries	96,828	Provena Health Services	100.00%	81,137		(15,691)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	51,853		51,853	20
21	V	30 Depreciation		Provena Health Services	100.00%	61,378		61,378	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	18,269		18,269	22
23	V	17 Information Systems Salaries	145,661	Provena Health Services	100.00%	77,265		(68,396)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	28,847		28,847	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	24,785		24,785	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	11,213		11,213	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	46,192		46,192	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	32,014		32,014	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	25,225		25,225	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	42,822		42,822	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	173,594		173,594	31
32	V	39 Ancillary Services - Other	727,902	Provena Senior Services Pharmacy	100.00%	727,902			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 970,391			\$ 1,595,161	\$ *	624,770	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena McAuley Manor # 0042879 Report Period Beginning: 01/01/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Provena McAuley Manor

0042879

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Provena Senior Services
 Street Address 19065 Hickory Creek Drive, Ste 310
 City / State / Zip Code Mokena, IL60448
 Phone Number (708)478-7900
 Fax Number (708)478-5387

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Management Fee Income	6,810,879	19	\$ 28,423	\$ 491,820	\$ 2,052	1	
2	5	Utilities	Management Fee Income	6,810,879	19	37,672	491,820	2,720	2	
3	6	Maintenance - Other	Management Fee Income	6,810,879	19	10,148	491,820	733	3	
4	11	Activities-Special Events	Management Fee Income	6,810,879	19	3,032	491,820	219	4	
5	17	Admin - Misc. Other	Management Fee Income	6,810,879	19	77,835	491,820	5,621	5	
6	17	Administrative Salaries	Management Fee Income	6,810,879	19	2,702,403	2,702,403	491,820	195,143	6
7	19	Professional Services	Management Fee Income	6,810,879	19	428,802	491,820	30,964	7	
8	20	Dues,Subscriptions	Management Fee Income	6,810,879	19	75,736	491,820	5,469	8	
9	21	Clerical Supplies	Management Fee Income	6,810,879	19	88,333	491,820	6,379	9	
10	22	Employee Benefits	Management Fee Income	6,810,879	19	1,175,007	491,820	84,848	10	
11	23	Education/Conference	Management Fee Income	6,810,879	19	32,966	491,820	2,381	11	
12	24	Travel	Management Fee Income	6,810,879	19	58,096	491,820	4,195	12	
13	26	Insurance	Management Fee Income	6,810,879	19	(818)	491,820	(59)	13	
14	30	Depreciation	Management Fee Income	6,810,879	19	37,881	491,820	2,735	14	
15	32	Interest	Management Fee Income	6,810,879	19	2,299,667	491,820	166,061	15	
16	34	Rent - Facility	Management Fee Income	6,810,879	19	293,923	491,820	21,224	16	
17	35	Rent - Equipment	Management Fee Income	6,810,879	19	36,626	491,820	2,645	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 7,385,732	\$ 2,702,403	\$ 533,330	25	

Facility Name & ID Number Provena McAuley Manor

0042879

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Provena Health Services
 Street Address 9223 West St. Francis Road
 City / State / Zip Code Frankfort, IL 60423
 Phone Number (815)469-4888
 Fax Number (815)469-4864

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,290,832	9	\$ 1,081,653	\$ 1,081,653	96,828	\$ 81,137	1
2	22	Employee Benefits	Operating Expense	1,290,832	9	691,262		96,828	51,853	2
3	30	Depreciation	Operating Expense	1,290,832	9	818,246		96,828	61,378	3
4	34	Rent Facility	Operating Expense	1,290,832	9	243,546		96,828	18,269	4
5	19	Admin Consulting,Other	Operating Expense	1,290,832	9	1,030,040		96,828	77,265	5
6	17	Information Systems Salaries	Operating Expense	1,941,141	9	384,433	384,433	145,661	28,847	6
7	22	Information Systems Benefits	Operating Expense	1,941,141	9	330,293		145,661	24,785	7
8	17	Information Systems - Other	Operating Expense	1,941,141	9	149,433		145,661	11,213	8
9	17	Admin Salaries	Direct Cost	1,290,832	9	615,798	615,798	96,828	46,192	9
10	17	Information Systems Salaries	Direct Cost	1,941,141	9	426,627	426,627	145,661	32,014	10
11	6	Information Systems - Equip Maint	Direct Cost	1,941,141	9	336,162		145,661	25,225	11
12	19	Admin Consulting,Other	Direct Cost	1,290,832	9	570,873		96,828	42,822	12
13	32	Admin - Interest Expense	Direct Cost	1,290,832	9	2,314,209		96,828	173,594	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 8,992,575	\$ 2,508,511		\$ 674,594	25

Facility Name & ID Number Provena McAuley Manor

0042879

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization

Provena Senior Services Pharmacy

Street Address

1475 Harvard Drive

City / State / Zip Code

Kankakee, IL 60901

Phone Number

(815)928-6141

Fax Number

(815)946-3238

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 727,902	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 727,902	25

Facility Name & ID Number

Provena McAuley Manor

0042879

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	Home Office Allocation					\$	\$		\$	166,061	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$		\$	166,061	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$		\$		14							
15	TOTALS (line 9+line14)					\$	\$		\$	166,061	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	_____	8
	2005	_____	9
	2006	_____	10
	2007	_____	11
	2008	_____	12
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Provena McAuley Manor

0042879

Report Period Beginning:

01/01/09

Ending:

12/31/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	87	1986	1986	\$ 4,218,962	\$ 168,758	25	\$ 168,758	\$	\$ 3,965,825
5									
6									
7									
8									
Improvement Type**									
9	Various		1987	9,470		15			9,450
10	Various		1988	35,230	592	17	592		33,257
11	Various		1989	7,670		15			7,670
12	Various		1990	2,400		15			2,400
13	Various		1991	11,296		13			11,168
14	Various		1992	1,500		10			1,500
15	Various		1993	7,744		9			7,744
16	Various		1994	18,925		8			18,925
17	Various		1995	22,015		8			22,015
18	Various		1996	63,956	4,152	10	4,152		54,627
19	Various		1997	7,144		4			7,144
20	Various		1999	2,941		5			2,941
21	Various		2000	31,736	1,527	15	1,527		15,705
22	Various		2001	62,210	5,129	9	5,129		57,246
23	Various		2002	57,057	4,572	8	4,572		47,149
24	Various		2003	65,471	5,464	10	5,464		35,549
25	Various		2004	92,928	9,481	12	9,481		52,027
26			2005	233,353	19,042	10	19,042		82,783
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Provena McAuley Manor

0042879

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	REPLACEMENT OF PATIENT R	2006	\$ 28,498	\$ 1,900	15	\$ 1,900	\$	\$ 5,700	37
38	KITCHEN / DINING ROOM	2006	14,986	1,499	10	1,499		4,741	38
39	RENOVATION OF 7 BATHROOM	2006	11,471	765	15	765		2,677	39
40	ROOF REPAIRS	2006	8,950	895	10	895		3,133	40
41	DOOR REPLACEMENT LOWER C	2006	5,350	357	15	357		1,248	41
42									42
43	HVAC WORK (CHILLER)	2007	159,900	10,660	15	10,660		26,650	43
44	KITCHEN MUA UNIT	2007	86,736	5,782	15	5,782		14,456	44
45	FIRE ALARM SYSTEM	2007	74,690	7,469	10	7,469		18,673	45
46	CCTV, ACCESS CNTRL, AND	2007	45,830	4,583	10	4,583		11,068	46
47	BLANKET WARMER	2007	10,199	1,020	10	1,020		2,550	47
48	DINING ROOM FLOORING	2007	9,600	960	10	960		2,400	48
49	STAINLESS WALL BACKING -	2007	6,737	674	10	674		1,684	49
50	PLUMBING WORK	2007	5,858	293	20	293		732	50
51									51
52	DINING ROOM	2008	12,187	1,219	10	1,219		1,259	52
53	BATH & SHOWER ROOM REMODEL	2008	17,549	1,755	10	1,755		2,632	53
54	ROOF REPAIR	2008	6,490	649	10	649		974	54
55									55
56	DRAIN REPAIRS	2009	6,683	477	7	955	477	477	56
57	ROOF REPLACEMENT	2009	89,000	4,450	10	8,900	4,450	4,450	57
58	FIRE DOOR	2009	14,215	474	15	948	474	474	58
59	CEILING AND PIPE REPAIRS IN CONVENT	2009	13,125	656	10	1,313	656	656	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,580,059	\$ 265,252		\$ 271,310	\$ 6,057	\$ 4,541,756	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 535,032	\$ 53,196	\$ 53,196	\$	10	\$ 192,513	71
72	Current Year Purchases	56,685	2,664	5,328	2,664	9	2,664	72
73	Fully Depreciated Assets	146,365				9	146,365	73
74	Home Office Allocation		64,113	64,113				74
75	TOTALS	\$ 738,082	\$ 119,973	\$ 122,637	\$ 2,664		\$ 341,542	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Plant Engineering	1999 Ford Eldorado	1999	\$ 42,261	\$	\$	\$	8	\$ 42,261	76
77										77
78										78
79										79
80	TOTALS			\$ 42,261	\$	\$	\$		\$ 42,261	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,360,403	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 385,225	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 393,947	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,722	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,925,559	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5	Home Office Allocation				21,224			5
6								6
7	TOTAL				\$ 21,224			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 48,453 Description: Nursing \$38,424; Activities \$7; Dietary \$131; Plant Eng \$269; Admin \$6,977; Home Office \$2,645

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a,3	hrs	\$	5,541	\$ 353,731	\$	5,541	\$ 353,731		5,541	\$ 353,731				1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		590	38,012		590	38,012		590	38,012				2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a,3	hrs		7,001	447,984		7,001	447,984		7,001	447,984				4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39,3	# of prescripts						732,605			732,605				9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$	13,132	\$ 839,727	\$	13,132	\$ 839,727	\$ 732,605	13,132	\$ 1,572,332				14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Provena McAuley Manor**# **0042879**Report Period Beginning: **01/01/09**Ending: **12/31/09****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/09**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 12,337,938	\$	1
2	Cash-Patient Deposits	107,856		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	12,517,618		3
4	Supply Inventory (priced at)	682,337		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,512		6
7	Other Prepaid Expenses	152,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 25,819,261	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,398,236		12
13	Land	6,820,469		13
14	Buildings, at Historical Cost	85,287,605		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,957,385		16
17	Accumulated Depreciation (book methods)	(56,011,567)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	106,392		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 62,558,520	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 88,377,781	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 5,373,551	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,366,224		28
29	Short-Term Notes Payable	52,481		29
30	Accrued Salaries Payable	3,681,842		30
31	Accrued Taxes Payable (excluding real estate taxes)	113,556		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,098,515		32
33	Accrued Interest Payable	17,377		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Party</u>	913,853		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 12,617,399	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,170,110		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	382,071		42
Other Long-Term Liabilities(specify):				
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,990,925	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,608,324	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,769,457	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 88,377,781	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,629,105	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(5,368,199)	3
4	Adj. To reconcile consolidated equity & consolidated income	4,331,027	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 72,591,933	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	480,097	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	857,343	11
12	Expenditures for Specific Purposes	(159,916)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,177,524	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,769,457	24 *

* This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,527,358	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,527,358	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,525,151	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,525,151	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,133	13
14	Non-Patient Meals	8,893	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	712,923	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	27,288	20
21	Other Medical Services		21
22	Laundry	22,080	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 786,317	23
D. Non-Operating Revenue			
24	Contributions	50,552	24
25	Interest and Other Investment Income***	6,850	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 57,402	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	288,358	28
28a	<u>Misc Income & Gain/Loss SOFA</u>	180,631	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 468,989	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,365,217	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,063,489	31
32	Health Care	3,591,735	32
33	General Administration	2,126,272	33
B. Capital Expense			
34	Ownership	328,089	34
C. Ancillary Expense			
35	Special Cost Centers	727,902	35
36	Provider Participation Fee	47,633	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,885,120	40
41	Income before Income Taxes (line 30 minus line 40)**	480,097	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 480,097	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Provena McAuley Manor**

0042879

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,068	\$ 103,634	\$ 50.11	1
2	Assistant Director of Nursing	1,880	2,080	76,997	37.02	2
3	Registered Nurses	26,501	28,491	889,443	31.22	3
4	Licensed Practical Nurses	8,630	9,135	230,545	25.24	4
5	CNAs & Orderlies	58,299	63,432	935,258	14.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,655	4,480	67,134	14.99	8
9	Activity Director	1,880	2,080	19,377	9.32	9
10	Activity Assistants	5,410	5,889	48,311	8.20	10
11	Social Service Workers	2,760	2,960	45,999	15.54	11
12	Dietician	1,472	1,596	24,819	15.55	12
13	Food Service Supervisor	2,012	2,123	28,008	13.19	13
14	Head Cook	5,824	6,265	52,690	8.41	14
15	Cook Helpers/Assistants	11,950	12,931	91,012	7.04	15
16	Dishwashers					16
17	Maintenance Workers	4,998	5,481	87,852	16.03	17
18	Housekeepers	13,226	14,398	149,117	10.36	18
19	Laundry	2,558	2,751	30,842	11.21	19
20	Administrator	1,840	2,080	104,875	50.42	20
21	Assistant Administrator	1,696	2,080	73,228	35.21	21
22	Other Administrative	6,200	6,726	124,474	18.51	22
23	Office Manager					23
24	Clerical	6,070	6,707	57,466	8.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral</u>	1,834	2,080	36,838	17.71	33
34	TOTAL (lines 1 - 33)	170,615	185,833	\$ 3,277,919 *	\$ 17.64	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	97	\$ 4,974	1,3	35
36	Medical Director	\$1000/mo	11,000	9,3	36
37	Medical Records Consultant	28	2,065	10,3	37
38	Nurse Consultant	7	725	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,319	11,3	44
45	Social Service Consultant	36	2,200	12,3	45
46	Other(specify)				46
47	<u>Prior Year Adj - Medical Director</u>		(25,546)	9,3	47
48	<u>Rehab Medical Director</u>	\$1500/mo	18,000	9,3	48
49	TOTAL (lines 35 - 48)	184	\$ 14,737		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	195	\$ 11,441	10,3	50
51	Licensed Practical Nurses	35	1,477	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	230	\$ 12,918		53

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0042879

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Ending:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Service Network \$4378
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 87
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,253 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 47,633
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,893
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.